Objectives:

- Describe a comprehensive needs assessment for home-based palliative care
- Understand the ways in which funding source impacts program design
- Discuss staffing requirements for a home-based program
- Define program metrics that lead to sustainability
Defining Palliative Care

- Multi-disciplinary approach to care of patients with serious illness
- Goal: Improve quality of life for patient and family
- Focused on relief from symptoms, pain, and stress of serious illness – whatever the diagnosis
- Appropriate at any age and any stage in a serious illness
- Provided together with curative treatment
Palliative Care: Support for Living

- Focuses on **living** with serious illness
- At any age, at any stage
- Alongside curative therapy
- Not synonymous with end of life care
Palliative care vs. hospice care

Palliative care is aimed at anyone who has been diagnosed with a life-threatening illness.

Hospice care is mostly aimed at patients who have been diagnosed with a terminal illness.

Palliative care helps maintain quality of life and reduce illness symptoms – and recent findings suggest that cancer patients who receive palliative care alongside standard treatments can live longer.

Hospice care is aimed at providing patients with a dignified, pain-free death – in the U.S., hospice care is mostly meant to be administered inside the patient’s home.
The Most Comprehensive and Integrated Health Network in New Jersey

Hackensack Meridian Health Overview

Licensed Acute Beds
4,024

Hospitals
2 Academic
9 Community
2 Children’s

Team Members
27,986

Home Care
Over 19,000 visits annually

Acute Admissions
153,185

Physicians
6,006

ER Visits
568,431

Medical Residents
503

Fitness Members
30,000

Rehab
16 Facilities

Net Revenue
$4.1B
• Continuous reporting analysis  
• Performance Improvement  
• Standardization of assessments and care  
• Initial, follow-up, psychosocial, spiritual, and family conferences

Palliative Care Database

Home-Based Program
- Serious Chronic or Advanced Illness
- Difficulty leaving the home
- Interventions: symptom management, ACP, psychosocial and spiritual support
- Team approach: NP, RN, SW, Chaplain, MD oversight
- Seen across continuum [home, ALF, SAR, etc.]

Inpatient
- Any of MH's 7 Acute Care Hospitals
- Physician Order
- IDT Team: MD, NP, SW, Chaplain
- Daily care until discharge or transition

Skilled Nursing Facility
- Any of MH's 5 SNFs and 1 ALF
- Physician Order
- IDT Team: NP, SW, Chaplain, MD oversight
- Consultative service

Outpatient Practice
- Various locations "without walls" (e.g. CHF and cancer clinics)
- No referral required
- MD, NP, SW, Chaplain

Navigational Key
- Discharges and Transitions of Care
- Quality Initiatives

Palliative Care Service

Discharges and Transitions of Care
- Quality Initiatives
Palliative Care at Hackensack Meridian Health

Follows high risk, high acuity patients
- Multiple co-morbidities
- Functional impairment

Provides coverage across the continuum
- Inpatient
- Skilled nursing facilities
- Home
- Outpatient

How Did We Get Here?

- Alignment with health network’s strategic mission and goals
  - Survived a change in funding
  - HMH has provided leadership and resources to staff and implement programs and tools to sustain growth
  - “C Suite” understands that palliative care contributes to the bottom line
Moving Outside the Hospital Walls

• Excelled at providing palliative care at point of crisis (inpatient setting)
• Recognized that upon discharge, palliative care plans not following patients beyond the hospital walls
• Mission: Provide palliative care across care transitions and at home
Needs Assessment

• Critical to program development and design
• Consider partnerships, resources, data
• Do not skip this step

Needs Assessment: Partners

• Met with hospital and corporate leaders, partner companies
  • Gained understanding of system goals
    • Management of high risk populations
    • Cancer, CHF, COPD
    • Integration with ACO and clinically integrated network
  • Obtained buy-in from key leaders
**Needs Assessment: Data**

- Worked with IT and data management
- Determined highest acuity, highest cost patients
- Analyzed variables by disease state:
  - Direct and indirect costs
  - Admissions
  - Readmissions
  - LOS
  - ICU days/costs
- Developed target patient groups
  - Algorithms for patient identification

**Needs Assessment: Resources**

- Examined existing resources
- Met with teams and reviewed:
  - Staffing models
  - Documentation
  - Data collection
- Determined gaps for home-based care
- Developed a uniform model
Defining Program Goals and Objectives

Setting Impacts Goals and Objectives

- Independent
- Part of a health system or hospital
- Part of a hospice or home health agency
- Affiliated with a physician practice
Setting for Our Home-based Program

- Integrated health system in central NJ
- Monmouth and Ocean counties
  - Suburban
  - High percentage of elderly
  - Socioeconomic diversity
- Patients followed at home
  - Independent residence
  - Assisted living

Hackensack Meridian Health Program Goals

- Provide a fully integrated palliative care program for patients and families facing challenges of serious illness
- Follow patients across care transitions
- Develop a program that is reproducible
Hackensack Meridian Health
Program Objectives

• Improve quality of life of patients and families
• Provide aggressive management of physical symptoms and psychosocial stressors
• Provide patients and families with education and emotional support needed to make informed decisions relative to end of life care
• Coordinate care among physicians, facilities, services, family and community outside hospital walls

Defining a Target Population and Core Services
Choosing a Target Population

• Which patients will the program serve?
  • High healthcare utilization
  • High illness burden
  • Conditions/diagnoses associated with limited prognosis

Hackensack Meridian Health Target Population

• Serious illness with high symptom burden or psychosocial need
• Difficulty leaving the home
Hackensack Meridian Health Demographics

- Majority of patients are female (63%)
- Elderly population with average age = 80
- Range of illness severity but all with difficulty leaving the home

Hackensack Meridian Health Disease States

<table>
<thead>
<tr>
<th>Disease States</th>
<th>Percentage</th>
</tr>
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<tbody>
<tr>
<td>Cancer</td>
<td>31%</td>
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<tr>
<td>Cardiac</td>
<td>17%</td>
</tr>
<tr>
<td>Dementia</td>
<td>17%</td>
</tr>
<tr>
<td>Frailty/debility</td>
<td>10%</td>
</tr>
<tr>
<td>Pulmonary</td>
<td>9%</td>
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</table>
Core Services

• What services does the target population most require?
• Consider building services around team expertise

Hackensack Meridian Health Core Services

• Pain and symptom management
• Psychotherapy
• Advance care planning
Models of Funding

- Fee for service
- Case rate/Episodic
- Capitation
Hackensack Meridian Health as an Example of Sustainability

- Started as a Medicare Demonstration
  - PMPM care management fee
  - Large scale
- Program adaptation for fee for service model
  - Change in program design
  - Change in staffing

Hackensack Meridian Health Funding

- FFS billing
- Partnership with home care and hospice
- Grant support
- New pilot with commercial payer
Staffing Requirements

Program Staffing

- Management
- Clinical Staff
- Administrative staff
Clinical Staffing at Hackensack Meridian Health

- Maximum ratio is 133 patients per team
- Team based approach (APN, RN, SW, office-based RN, chaplain)
- Goal of 5 visits per day
- Adequate administrative support is key

Administrative Roles

- Reception and scheduling
- Insurance management
- Data collection, entry, and monitoring
- Program marketing
- Facility management
- Information technology
- Finance/business management
- Human resources
- Risk management
Management and Administrative Staff at Hackensack Meridian Health

- Medical director
- Administrative director
- Outcomes analyst
- 4 administrative staff
  - Receptionists/schedulers
  - Overlap with other Palliative Care programs

Models of Home-Based Palliative Care
Models of Home-Based Palliative Care

- Consultative
- Co-Management
- Primary care

Team Composition

- Palliative care requires an interdisciplinary team
- Mix of providers based on
  - Patient population
  - Funding sources
  - Clinical model
  - Type of visits
Types of Interventions

- Assessment and management of:
  - Physical symptoms
  - Psychosocial stressors
  - Spiritual needs
- Ongoing follow-up of all of the above needs
- Psychotherapy
- Disease-specific patient education
- Advance care planning
- Education (mailing, videos, discussions, events)

Interventions January-May 2017

<table>
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<tr>
<th></th>
<th>Face-to-Face Visits</th>
<th>Phone Interventions</th>
<th>Total</th>
<th>Total per FTE</th>
<th>% by FTE</th>
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<tbody>
<tr>
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<td>457</td>
<td>149</td>
<td>606</td>
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<tr>
<td>RN</td>
<td>186</td>
<td>216</td>
<td>402</td>
<td>201</td>
<td>25%</td>
</tr>
<tr>
<td>SW</td>
<td>542</td>
<td>703</td>
<td>1245</td>
<td>311</td>
<td>38%</td>
</tr>
</tbody>
</table>
Methods of Scheduling

- Visits Per Day
- Caseload
- Geographic/Territory
- Mixed
- Face-to-face visits range from several times per month to once every three months
  - Initial visit 90 minutes
  - Follow-up visit 45 minutes
  - Post Hospitalization follow-up visit 60 minutes

Coverage

- Business hours, off-hours, vacations, weekends
- May be dependent on partnerships & organization structure
Referrals

- Clarify eligibility criteria
- Identify who will make referrals
- How will referrals be made
- What type of follow up is done with referrers

Use of Technology

- Laptops
- Hotspots/Air cards
- Smartphones
- Portable scanners
- Faxing via EMR
Care Integration

- Palliative care patients are flagged in all systems
  - Inpatient, outpatient, case management
- Electronic notification when patients admitted to the hospital, ED, or LTC/SAR
- Notification of admission to hospice

Maintaining Uniformity

- Single EMR across settings
- Provider training
  - UNIPAC
  - Required CAPC modules
  - Shadowing in multiple settings
- Compassion fatigue days
- System-wide meetings bi-monthly
- Hospital-wide IDT meetings monthly
Defining Metrics

- Evidence-based, national guidelines
  - CAPC, National Quality Forum
- Must be measurable
- Must matter to the right people
- Accountability
  - Method for reporting on results
  - Quality improvement, outcomes committees
Hackensack Meridian Health Process Measures

- Caseload by FTE
- Patient census/panel by title
- Enrollment at start and end of period

Hackensack Meridian Health Quality Measures

- Advance care planning
  - ACP chart created with follow-up note
  - Hand held scanners for clinicians

- Assessment of physical symptoms (pain, dyspnea, nausea)
  - ESAS scale
  - Alerts to clinicians for follow-up

- Patient and family satisfaction
  - Prompt follow up
  - Photograph on survey
Hackensack Meridian Health Outcomes Measures

- Admissions
- LOS
- ICU days
- Skilled nursing days
- Hospice referrals and hospice days
- Hospital cost savings

Transitions of Care

- 77% of hospice eligible patients transitioned to hospice
- 60% difference from hospice average LOS for 2017
  - HMH Hospice average LOS: 14 days
  - HMH PC patients average hospice LOS: 26 days
Putting It All Together: One Patient’s Journey
DJ’s Experience with Palliative Care

- 88 year-old woman with COPD, anxiety, GI bleeding, recent brain stem aneurysm, melanoma right foot s/p excision
- Enrolled in palliative care program November, 2014
- Primary complaints: weight loss, knee pain, falls

Palliative Care Interventions

- Managed her knee pain
- Identified poorly fitting dentures contributed to weight loss and helped her get to dental clinic
- Reconciled medications and stopped NSAIDS
- Arranged home PT
- Recommended pulmonary rehab and worked with pulmonologist to get it ordered
- Identified non-healing wound and got patient to wound clinic
Palliative Care Interventions

- Increased home care services
  - Medicaid and JACC (Jersey Assistance for Community Caregiving)
- Emotional support
- Coordinated hospital admission, rehab admission and discharge home
- POLST completed with patient and daughter and provided to primary MD
Lessons Learned

• Buy-in from leadership is key to sustainability
• Program must align with organizational goals
• Education is critical and must be continuous
• Palliative care requires an interdisciplinary team (regardless of ability to generate revenue)
• Metrics must be measurable, appropriate for the home setting and aligned with the health system’s strategic goals

Threats and Challenges

• Continued funding
• Finding trained staff
• Push to be more time efficient
• Keeping up with health system growth
Thank you!